IDAHO DEPARTMENT OF HEALTH & WELFARE

RESIDENTIAL ASSISTED LIVING FACILITIES (RALFS) OR CERTIFIED FAMILY HOMES (CFHS)

Exception Request Form for Aged and Disabled Waiver and State Plan Personal Care Services Participants

Provider:	
Participant Name:	
Participant MID:	
Setting Quality that Requires Exception	
Assessed Needs	

Prior Interventions and Supports	
Prior Methods	
Intervention Description	

Data Collection	
Time Limit	

My signature on this form indicates that I am aware of and agree with exception outlined on this form. I was provided with the information I needed to make an informed decision about this exception.

Participant Information	
Name:	Date:
Participant Signature:	
Legal Guardian (if applicable)	
Name:	Date:
Legal Guardian Signature:	
Address:	City, State, Zip:
Phone:	Alternate Phone:

My signature on this form indicates that I am aware of and agree with the risks outlined on this form. I am responsible for implementing this exception as documented. My signature assures that no harm will come to the participant based on the interventions and supports used for the exception.

Agency Information	
Name of Agency:	Date:
Agency Signature:	

For Department use only

☐ **Approved** _____ _____

☐ **Denied** **Authorizing Signature** **Date**

Comments: